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Different Approaches to Cross Boreder Mobility of Patients in the European Union in Czechia, Slovakia and Poland

FILIP KŘEPELKA

Abstract Czechia, Poland and Slovakia are neighbour countries with similar history and socioeconomic conditions. They share heritage of socialized healthcare. Nevertheless, they adopted different policies towards promotion of patients' mobility in the European Union. Accession to coordination of social security establishing assistance for tourists was smooth. Providers offer quality care for good prices. Foreign patients come to all three countries. Right for reimbursement of treatment intentionally sought across borders was created by the Court of Justice already before their accession. Nevertheless, they already decided on the Patients' directive. Czechia supported it, Slovakia abstained and Poland refused. Numerous Poles seek treatment abroad and ask for its reimbursement, while implementing legislation barely complies and authorities are tight-fisted. Few Slovaks do it in accordance with rules adopted with cautiousness. Czechs ignore this opportunity despite official benevolence. Quality of healthcare, various price-setting and peculiarities of public financing explain this difference.

KEYWORDS: European Union • Free movement of services and goods • Medical tourism • Public financing of healthcare • Patients' rights

CORRESPONDENCE ADDRESS: Filip Křepelka, Ph.D., Associate Professor, Masaryk University, Žerotínovo nám. 617/9, CZ-60177 Brno, email: Filip.Krepelka@law.muni.cz.

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1 Introduction

While being teacher of both law of the European Union and healthcare/medical law, I am continuously interested in European integration of healthcare.

Considerable specifics of the East persist despite integration of Central European, Baltic and Balkan countries it this supranational structure. There are different political, economic and social conditions in these countries. Some ones are relics of communist regimes. Contrary to naïve expectations, they are persistent and even perpetuated.

Research projects addressing integration often focus situation in the elder member states, especially those ones in its core along Rhine.[1] Therefore, I was glad to be invited to research project of the University of Copenhagen "Healthcare Regulation in the European Union; A Policy-Cycle Study of Complex Decision Making and Implementation",[2] supported by the Danish Research Council. The project addressed political aspects of healthcare integration starting with the case-law of the Court of Justice establishing right for reimbursement of non-urgent healthcare found in the other member states stabilized with the Directive 2011/24/EU on Application of Patients' Rights in Cross-border Healthcare.

Coordinator of the project *Dorte Sindbjerg-Martinsen* with *Karsten Vrangbaek* point out that even Denmark as an elder member state with national healthcare service system is distant from efforts tailored for the member states with public health insurance (Martinsen & Vrangbaek, 2008). *Nikolay Vasev* and *Karsten Vrangbaek* described the participation of new member states at the beginning as "dead letters and empty treasury boxes", but later identified together with me various modes of compliance with the case-law and the Directive (Vasev, Vrangbaek & Krepelka, 2016).

Czechia, Poland and Slovakia are neighbours with shared history and similar economic, political and social conditions. Nevertheless, Czechia supported the Directive, Poland refused it and Slovakia abstained. The last two countries feared outflow of money with outgoing patients and indeed face it.

I find information in the two countries thank knowledge of their languages. It is insufficient to rely on English summaries and presentations. I had also an opportunity to discuss the topic of cross-border healthcare with experts in Slovakia and with legal scholars in Poland.

I thank for opportunity to present detailed results of the research in journal "Medicine, Law and Ethics" of the law faculty of the University in Maribor. Slovenia is another new member state with heritage of nationalized healthcare also involved in cross-border healthcare.

2 Integration of healthcare in the European Union

Free movement of patients started with journeys for privately paid treatments. This movement was unhindered. There is little justification for control of nationals undergoing treatment abroad. Relaxation and cessation of migration controls made it impossible. Liberalization was thus confirmed accidentally due to restrictions of related payments in *Luisi and Carbone*.[3]

Freedom was guaranteed thanks European integration even for individuals seeking treatment restricted in their home member states such as abortion[4] and assisted reproduction.

The European (Economic) Community addressed medical aspects of migration among growing number of the member states with regulations for coordination of social security 1408/71, later replaced with regulation 883/2004.

Migrant workers, self-employed persons and their family members – nationals of the member states enjoying broad migration rights, but later also resident aliens - shall enjoy publicly financed healthcare in host member state. They pay taxes and contributions there. Commuters and family members left in home member state can opt and enjoy coordinated financing respectively.

Real benefit of integration is public financing of urgent treatment of tourists. Reimbursement channels developed within the legal framework. Its ubiquity is symbolized with standardized European Health Insurance Card (EHIC) issued now for half billion Europeans.[5]

Public financing of medical treatment sought and found in other member state than state of affiliation was and is feasible for countries lacking capacities for specialties or facing shortcomings. Mentioned framework established one channel for it. Other arrangements are not excluded.

While interpreting free movement of services and goods, the Court of Justice established in *Kohll*[6] and *Decker*[7] an individual right for public financing of treatment and medical device intentionally sought in the other member states.
This approach was questioned by the member states fearing destabilization of healthcare and claiming their competence to organize and finance it.

Despite it, the Court sustained in subsequent judgments[8] *Vanbraekel, Miller-Fauré+van Riet, Smits+Peerbooms, Watts, Leichtle, Ioannidis, Elčinov* and *Petru* right for reimbursement of non-urgent treatment sought and found abroad despite various models of public financing. Nevertheless, safeguards for hospitalizations and expensive treatments were recognized by the Court facing extraordinary pressure of the member states.

Most member states preferred legislative stabilization with the Patients' Directive which further softened requirements of the Court of Justice (Hatzopoulos & Hervey, 2012). It required implementation with national legislation until October 2013. We can thus estimate first outcomes of this effort.

3 Implementation of the case-law and the Directive

3.1 Czechia

Above summarized case-law was respected by Czech public health insurance funds with tacitly agreed policy under auspices of the national contact point (below) (Poláková, 2013). Requests for reimbursement remained sporadic and were granted in most cases. No action was brought to the courts until 2013 when one specific case was pending.[9]

As mentioned, Czechia supported the Directive. Transposing legislation was adopted in April 2014 with *Zákon 60/2014 Sb.* amending *Zákon č. 48/1997 Sb. o veřejném zdravotním pojištění* (the Act of Public Health Insurance).

Seven months delay was caused with cabinet crisis and early election. The substance was uncontroversial. Competence to enact the list of treatments requiring prior authorisation is curtailed.[10] No list was adopted since then. Czechia thus joined few member states enabling any reimbursement without prior authorization.

Centrum mezistátních úhrad (CMU, Centre for Interstate Payments) renamed in 2016 *Kancelář zdravotního pojištění* (KZP, Chancellery of Health Insurance)[11] established by public health insurance funds under auspices of the Ministry of Healthcare after the accession in 2004 for interstate payments according to the regulations developed into excellent institution assuming also role of the national contact point despite long lasting lack of legislative recognition.

3.2 Slovakia

There was scarce information about impact of case-law after the accession of Slovakia. The funds balanced permissive and restrictive approach towards sporadic requests.[12] They escaped both media coverage and judicial review.

Slovakia transposed the Directive with detailed *Zákon 220/2013 Z.z.* amending *Zákon č. 588/2004 Z. z. o zdravotnom poistení* (Act on Health Insurance) with considerable impact on related and simultaneously adopted ministerial decree specifying list of treatments whose reimbursement requires prior authorization with *Vyhláška 341/2013 Z.z.*

The national contact point for realization of rights resulting from the Directive and for coordination is *Úrad pre dohlad nad zdravotnou starostlivosťou,* which is national supervisory authority for healthcare.[13]

3.3 Poland

Case-law of the court of Justice was argued by many Poles in actions against denial to reimburse. Nevertheless, administrative courts often refused actions of patients claiming reimbursement of treatment sought, found and paid in the other member states. Argumentation reveals limited significance of the case-law of the Court of Justice.[14]

The situation reversed in the period for implementation of the Directive known simply as *dyrektywa transgraniczna* (cross-border directive) and after its elapse. The Directive was swiftly applied according to settled case-law establishing its direct effect towards state few months after the implementation deadline.[15]

Poland implemented the Directive with considerable delay in November 2014 after intense deliberation with amendment[16] of *Ustawa o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych* (Act on Healthcare Services Financed by Public) adopted in 2004.

Unsurprisingly, related legislative provisions and adopted decree define treatment whose reimbursement requires prior authorization extensively as any hospitalizations, expensive pharmacotherapy plus numerous diagnostic methods. Procedure for reimbursement is cumbersome. Limits are fixed with legislation[17] for annual expenditures of the *Narodowy fundusz zdrowia* for various regimes of cross-border healthcare sought by Poles abroad.

Central administration of the *Narodowy fundusz zdrowia* is designated as authority for coordination and the national contact point.[18]

4 Mobility of patients

4.1 Czechia

Great Britain was described to be in splendid isolation in 19th century due to its refrain from alliances with European countries albeit it was centre of international trade. Czechia is not closed hermetically as regards cross-border movement of medical services.

The number of Czechs treated abroad reached thousands per year during last decades. Czechs realized in the first years of free travelling that urgent treatment abroad can be exorbitantly expensive. Travel insurance has become routine

solution. The number of foreigners treated in Czechia is even bigger. Millions tourists visit Prague annually. Thousands need medical help due to sudden illness or injury.

Several tourists from other European countries enjoy reimbursement of their healthcare according to mentioned rules. Many injured and ill tourists rely further on their travel insurance due to its advantages such as instant phone and e-mail assistance in case of disease and injury, reimbursement of prices claimed by providers above reimbursed public rates, coverage of healthcare provided by providers uncontracted for public financing and expensive repatriation. Many Czechs abroad also prefer this way.[19]

Immigration and emigration has also consequences for public financing. Residence has become criterion for affiliation instead of citizenship. Immigrants are included an expatriates excluded. Citizens of the non-member states with medium and long-term residence are excluded from public health insurance. Their mandatory insurance is the most important commercial insurance in Czechia. However, it has considerable exclusions. Urgent treatment must is provided to uninsured foreigners and unpayable debt emerges. Ombudsman and human right activists criticize the exclusion.[20] On the opposite, Czechs can return easily to the system providing comprehensive care for free with restoration of their residence in Czechia. They can be perceived as free-riders while they escape contributions.

The biggest money transferred among authorities relates to commuting workers - both Czechs abroad and citizens of the other member states commuting to Czechia - affiliated in the member states of their employment, but treated in their country of residence. However, I suggest ignore the phenomenon while addressing cross-border movement of patients. These people are treated in their home state. Solely money for it crosses border.

Medical tourism emerged during last decades. Several providers started to offer their medical services for paying patients for treatment unavailable, restricted or expensive in their home countries. Dentistry, assisted reproduction (Křepelka, 2011) and advanced surgery can be mentioned. Czechia started to promote itself as destination for medical tourism.[21]

No significant outflow of rich patients paying for excellent healthcare is apparent. Even the richest patients are treated mostly in Czechia. Private clinics emerged and provide care of excellent quality cheaper than abroad.

Otherwise, Czech hospitals remain rather egalitarian. People of all social strata meet there. Healthcare shall be equal for every insured. Real equality is questioned. Many believe that bribes are necessary for good care. It is difficult to distinguish corruption from presents given by patients symbolizing gratitude for care provided by underpaid physicians and nurses. Independent experts claim that

expensive innovative treatments are often denied to patients incapable to investigate options and communicate with physicians.[22]

Public health insurance funds are capable to spend exorbitant sums on individual patients without coercion.[23] This generosity does not stop at borders. The funds agree numerously in the last decade with financing of special treatment abroad if unavailable in Czechia. Specific genetic testing, innovative cancer treatment and complicated surgery available are financed to Czech patients selected according to medical necessity and perspectives. This care is mostly found in Germany. They form an episode of healthcare provided in Czechia. Demand usually requires recommendation of leading physicians maintaining international contacts.

Influx of patient within the framework is bigger. Slovaks seek treatment in Czechia. Their interest is often accepted by their public health insurance funds. Czech healthcare has good reputation in Slovakia. Czech physicians contributed to improvement of local healthcare during the 20th century. Many Slovaks work or have relatives in Czechia. By the way, Czech hospitals employ many Slovak physicians and nurses. Czech and Slovak are mutually intelligible languages. According to information of physicians, dozens of Britons seek treatment financed by their government in Czechia. Seeking capacities abroad relieving waiting lists in the National Healthcare Service achieved thus central Europe.

The number of foreign patients paying directly for their treatment in Czech hospitals, level of urgency, type of their treatment, and sums paid by them are not summarized by authorities. As mentioned, there are providers oriented at foreign clientele. However, no general hospital highlights foreign privately paying patients as crucial for its business.

Nobody investigated whether foreign patients paying in Czechia for their treatment enjoy reimbursement of their expenditures by private insurers or the authorities of their countries. Impact of the Directive and its implementation in other member states on influx to Czech hospitals is thus hard to estimate.

4.2 Slovakia

Slovaks are not deprived from treatment abroad. Slovak health insurance funds approve planned healthcare abroad to number of their clients.[24]

That number of requests for reimbursement after implementation of the Directive is significant. Three public health insurance funds existing in 2015 bargain on rates to be paid. They question from time to time whether particular treatment is reimbursable. Fraud was identified in some cases and suspected in others.[25] Migration of Slovak patients[26] and related outflow of public money, however, does not spark any debate in Slovakia.

4.3 Poland

It is difficult to estimate international mobility of Polish patients. According to opinions expressed in media and in conferences, thousands seek treatment abroad and many other contemplate it. The Directive can boost outflow of patients from Polish hospitals.

Czech healthcare belongs to prominent destinations of Polish patients. Influx of Polish patients to Czech hospitals and clinics is also significant. It was noticed in both Czechia and in Poland. Among others, cataract and glaucoma is treated by providers located in Ostrava agglomeration close to conurbation.

Healthcare abroad is sought also for abortions restricted in Poland and unavailable even if permitted. Despite reputation of pro-choice country, Slovak providers serve more Polish women seeking abortion than Czech ones.

5 Incentives for mobility and obstacles to it

5.1 Czechia

Czech patients started to sue their healthcare providers for damages. Malpractice is reported frequently to the police and result sometimes into criminalisation of physicians and nurses. Judges are thus confronted with medical law.

Healthcare becomes battlefield of human right activism. *Liga lidských práv,* (LLP, League of Human Rights)[27] is prominent organization. Its activists are educated and trained graduates of law and social sciences. Nevertheless, they focus on autonomy and liberty of patients: extensive compulsory vaccinations, alleged manipulations in psychiatry and restrictions of planned home births and coercive practices in hospital births.

There is, however, no tradition of adjudication on access to treatment and its affordability. It has not been clear for decades whether hospital denying treatment or the competent public health insurance fund shall be sued.

Reimbursement of treatment sought and found in the neighbour countries as part of fair healthcare is no priority for human rights organizations. They would be surely familiar with the case-law, with the Directive and its implementation.

Newspapers informed several times about actions on behalf of patients denied expensive treatment. Nevertheless, the funds usually reacted with permissive approach. Czech courts thus do not get an opportunity to develop any methodology of identification of medical services to be reimbursed.

No tradition of litigation made argumentation with the case-law improbable. Specialized legal scholars, attorneys specialized in medical litigation, experts on healthcare management and competent officials knew about the first judgements already before accession. Follow-up judgments were also considered. The issue was presented at conferences about European integration and medical law. It was mentioned together with overviews of reimbursement of urgent treatment according to rules for coordination of social security. This issue was addressed in professional journals. Clients would surely find attorneys to argue.

Unsurprisingly, interest of judges suffering from chronic overload with cases of increasing diversity and complexity, quickly changing legislation and unstable interpretation for the case-law was zero.

Czech patients are not accustomed to pay for treatment and then to ask for reimbursement. Contemporary healthcare emerged from transformation of the national health service of socialist Czechoslovakia financed with block grants. Privatized ambulances and commercialized public hospitals are contracted by public health insurance funds covering their clients. Healthcare is largely for free. Attempts to introduce "regulatory fees" during the last decade failed.

Few rich people pay for treatment of superior quality or unfinanced innovative treatment offered by private providers. Private insurance companies do not offer policies covering better better care, because sufficient demand was not identified. Several hospitals considered the Directive and its implementation in the member states as an opportunity to extent their services and increase yields.[28] We can doubt that such assistance is really provided. It is generally feasible to cooperate with local attorney or adviser instead studying laws and communicating with foreign authorities.

The number of people asking for reimbursement of planned healthcare in the other member states is expected to increase. Young Czechs travel frequently and some work abroad. They master foreign languages. Number of them has experience with foreign healthcare. However, these migrants often realize that Czech healthcare has surprisingly good performance.

Seeking for alternatives restricted at home – assisted birth in private settings rejected vigorously by ob-gyn community can be also an impulse.[29]

Eventual increase of outflow of Czech patients will be surely gradual. Public health insurance funds will be thus capable to cope with it.

5.2 Slovakia

Slovakia provides healthcare of slightly inferior quality. Migration of Slovaks is bigger than in Czechia. There is constant immigration for jobs and studies to Czechia. Incentives for seeking treatment abroad are thus better.

5.3 Poland

Publicly financed healthcare in Poland has considerable shortcomings. Waiting lists, so-called *kolejki* (queues) are commonplace for many treatments.
Poland has significant sector serving privately paying patients. Shortcomings result from limited public financing. Personnel, equipment and material are available. Economic elites pay for healthcare in greater extent.

Millions of Poles migrated abroad during last two decades for jobs, many accompanied with families. We can assume that such long-term migration makes many people familiar with healthcare abroad thanks residence and affiliation to system of social security of host member state. Familiarity with healthcare abroad can serve even relatives which have never migrated.

6 Different political attitudes towards implementation of the Directive

6.1 Czechia

The right-centre cabinet downplayed its Eurosceptic stance with textbook-like economic liberalism in case of the Directive. Domestic healthcare was expected attractive for incoming patients. There was little fear of outflow of money. However, no studies of impact on Czech healthcare and its public financing were realized.

Hospital managers and physicians know that foreign patients unaffiliated with Czech health insurance funds are entitled to urgent care which reimbursed to the providers by national institutions. They know that travel insurance provide guarantees for other cases. They now foreign patients paying out of pocket. They are aware that urgent treatment of uninsured poor foreigners can result in unpaid bills. Nevertheless, they know little about promotion of patient mobility in the European Union with the case-law and the Directive.

There was limited interest shown by ministers and deputies for cross-border healthcare and its public financing. Certainly, widespread ignorance of Czech politicians to promotion of patients' mobility in the European Union should not be explained exclusively with its negligible impact. Political parties ignore important issues. Their capacity to recognise problems and to ascertain measures is perfunctory. Membership is little and declining. Parties lack expertise. Seeking politicians capable to discuss the position of his/her party on the topic was thus

unsuccessful. Central administration is fragile. High-ranking officials fluctuate. Expertise is compromised with underpayment. Mismanagement is frequent.

Both *Asociace nemocnic České republiky* (Association of hospitals of the Czech Republic) joining university and state hospitals and *Asociace českých a moravských nemocnic* (Association of Czech and Moravian Hospitals) joining smaller hospitals did not published any opinion on the Directive and it implementation. *Česká lékařská komora* (Czech chamber of physicians) with compulsory membership was similarly ignorant.

There are several rival patient organizations. They informed about the possibility of treatment abroad. Nevertheless, their membership and audience is old-aged. Elder patients are disinterested in any treatment abroad. Similarly, association of patients suffering from particular diseases did not highlight cross-border healthcare as solution or alleviation. [30]

Public health insurance funds still identified eventual threat and lobbied in the Chamber of Deputies and in the Senate for adequate statutory definition of treatment which can be subject of prior authorization.[31]

6.2 Slovakia

It is difficult to ascertain attitude towards the Directive and its implementation in Slovakia. Political parties presented no opinion on it. Information for patients provided by patient organizations does not go beyond summary of the Directive and referrals to legislation.

6.3 Poland

Opposition of Polish government towards the Directive confirm chronic problems in Polish healthcare (Krysiak, 2015). Polish government officials – including the then prime minister *Donald Tusk* - did not conceal dissatisfaction with expected outflow of public money to the other member states. They expressed lack of enthusiasm for the implementation (Lisowska, 2014).

Unsurprisingly, several deputies of the *Sejm*, senators, or *Rzecznik praw obywatelskich* (ombudsman) sided with unsatisfied patients. Failure to implement the Directive was highlighted by Polish patient organizations. The issue was covered by media to extent and intensity unseen in Czechia. Good knowledge of the issue even in Internet blogs and promotions. Legal assistance is offered by talented young attorneys presenting their in-depth expertize in the issue.[32] Unsurprisingly, implementation of the Directive was rather defensive, based on consideration of significant costs by government and particular authorities.[33]

7 Shared and different in Central Europe

Central European, Baltic and Balkan new member states differ widely as regards controversial treatments. Nothing divides Poland and Czechia than stance towards abortions. Most Czechs are decisively pro-choice. Surprisingly, Slovakia has similar reality despite higher religiosity. Restrictive approach in Poland and attempts to ban abortions entirely reveals considerable cleavage in attitude in neighbour post-socialist nations.

Persistent statism and paternalism in many post-socialist countries is reflected more in resistance towards patient autonomy unseen in other countries. Post-socialist countries require extensive vaccination. They suppress home births and assistance at them, as revealed in judgments of the European Court for Human Rights *Ternovszky v. Hungary*[34] and *Dubská and Krejzová v. Czech Republic.*[35]

Nevertheless, all countries abandoned "Semashko" model of total state ownership and management of healthcare. Professionals pushed for privatisation which prevailed in other sectors. Public institutions were also commercialized. On the other hand, population requires public financing. The three countries adopted different methods for balancing these demands.

7.1 Czechia

Limbo of politicians and experts is restricted to cross-border issues. Financing and organization of healthcare in general is sensitive issue.

Contributions of employees, employers, individual businessmen fluctuate in accordance due to economic cycle and efficacy of collection of contributions. Contributions of the state for economically inactive clients stagnate. They are redistributed among the funds.

Competition of public health insurance funds expected originally was suppressed within one decade. Fluctuation among the funds does not bring significant advantages. The funds - seven in 2016 – shall follow the same policy resulting in equalized coverage of population. Unsurprisingly, plurality of funds is questioned from time to time. Nevertheless, politicians were too weak to introduce single national fund. Fears of excessive power were voiced.

Public health insurance funds vary on development and maintenance of network of healthcare providers. Hospitals, clinics, institutions of special care and self-employed physicians perceive different policies.

Current public financing developed from fee-for-service towards plethora of lump-sums reflecting number of patients, required equipment and vigilance. There are complicated combinations of lump-sums and fees-for-service. Ceilings,

limitations and exclusions emerged. There is considerable differentiation among types of providers. Financing based on diagnosis-related-groups (DRG) was introduced but compromised with unreliable data.

Elaborate mathematical formulas with countless variables and coefficients are now used for distribution of money to Czech hospitals, clinics and practitioners. Czech hospitals engage increasingly experts capable to bill their activities to public health insurance funds at the best and to avoid penalizations.

Complexity, lack of transparency and suspicion of manipulation in favour of providers close to politicians attract judicial review. Annual ministerial decrees were thus repeatedly evaluated by the Constitutional Court asked by groups of deputies and senators supporting disadvantaged ones. The Court warned with – postponed - abolition of the decree for 2013.[36]

This pricing has consequences also for cross-border mobility. We can debate whether rates reimbursed to few patients enjoying non-urgent healthcare abroad are fair according to expectations of the case-law and the Directive. List of treatments and their prices for calculation of compensation by those liable for of injuries and illnesses and for non-contracted providers of urgent treatment shall be used. However, these rates differ widely from real expenditures thanks additional lump-sum component.

Similarly calculated prices hardly covering costs render unattractive recruiting of patients from the other member states. Few privately paying patients in Czech hospitals enjoyed special treatment with higher prices for it. The principle of equal treatment[37] seems to block free movement of patients under such conditions. Certainly, it is circumvented with charging higher prices for allegedly superior care. We can debate whether higher prices can be justified solely with complicated communication with foreign patients.

Czech legislation on public health insurance does not specify medical treatments covered by public health insurance funds to hospitals, practitioners and other healthcare providers in favour of their clients.

Innovative treatments are introduced thanks initiative of leading physicians and managers. Hospitals accept red figures with an effort to become the first and the best or cross-financing is tolerated. International multicentre clinical trials are also impulse for improvement.

They methods are generally welcomed if they are cheaper than existing healthcare. Financing of expensive novel treatment starts after bargaining of leading hospitals as designed centres of specialized care, public health insurance funds and the

Ministry. There is specific monitoring of efficacy of "highly innovative pharmaceuticals" resulting in allocation of scarce money.

It can be thus unclear whether particular innovative treatment intentionally sought and found abroad shall be reimbursed. However, it is largely theoretical problem because few patients are willing to pay considerable sums in advance and then ask for reimbursement.

Plurality of public health insurance funds provides for rather prudent and sometimes creative management of public money.[38] Officials of the funds know that failure to guarantee expected standard of healthcare to their clients can cause exodus to other funds and its destabilization. Non-profit nature contributes to generosity including sporadic demands for reimbursement of healthcare sought abroad.

7.2 Slovakia

Slovakia adopted similar model of plural public funds as Czechia. It attempted to commercialize healthcare further decade ago enabling private funds to organize public health insurance. Courageous measures were adopted. Contracts between funds and providers shall be published. Competition among providers has been encouraged with methods of calculation. Strict public supervision with rather clear standards was introduced.

Shortcomings of healthcare contrasting profits resulted in their suppression by subsequent cabinets. Investment disputes followed. The number of funds dropped to three and the fund established by the state is clearly dominant. Nevertheless, many features of reform survived.

The transition from socialism to democracy and market economy was gradual outcome of chronic regime crisis in Poland than in Czechoslovakia.

Poland introduced system of regional *kasy chorych* (*"Krankenkassen"*). Establishment of competing funds was expected. Nevertheless, shortcomings resulted into crisis. This crisis addressed with centralization. *Narodowy fundusz zdrowia* (NFZ, National Health Fund) was established for contracting various public and private providers of healthcare.

Among the three countries, Poland has the most centralized system of public financing of healthcare. It eases introduction of some measures and reflection of the development. Nevertheless, chronic insufficient financing, monopsony and recurrent government interventions contribute to poor performance of Polish healthcare.

8 Identification of push and pull factors

Performance of national healthcare seems to be decisive for patient mobility. Czech healthcare provides better treatment - ranked 13th among 35 countries in Euro Health Consumer Index 2015 if compared with other post-socialist countries including neighbour Slovakia ranked 24th and Poland ranked 34th. (BJÖRNBERG) [39]

Healthcare in the two neighbour countries is thus unattractive for Czechs. On the contrary, Czech healthcare is attractive for both Slovak and Polish patients.

Satisfactory performance of Czech healthcare together with public financing excluding negotiation of patients with public authorities, lack of better and cheap care abroad and language barrier explain relative isolation of Czech healthcare. Benevolence towards few Czechs requesting reimbursement of non-urgent treatment sought and found in the other member states prevents eventual tensions and downplays attention to opportunity to seek healthcare abroad.

Germany and Austria – ranked 7th and 12th respectively – provide better healthcare. However, medical treatments are labour-intensive services. Prices thus reflect higher wages. Healthcare is thus unattractive despite efforts of healthcare in adjacent *Länder* to attract Czech patients due to huge co-payment for most Czech patients widely satisfied with Czech healthcare.[40]

Language barrier is obstacle for many cross-border activities in the European Union. It is widely perceived as significant for cross-border movement of patients and even unsurmountable. (Nunez, 2012) Indeed, cross-border movement is significant among countries without language barrier, especially if other factors emerge, as case of small Luxembourg without available treatment on its territory and cheaper treatment in neighbourhood.[41]

It is hard to estimate whether Czech patients are less fit for communication with physicians, providers and administrative personnel abroad more than patients from other member states. Knowledge of foreign languages is poor. Nevertheless, identified obstacles and grounds for negligible resort to reimbursement largely coincides with factors highlighted also by researchers examining situation in West Europe. (Legido-Quigley et al., 2012)

Shortcomings of Polish and Slovak healthcare – waiting lists, widespread unavailability of innovative treatments, and perfunctory quality of many other treatments - seem to be impulse for several patients to seek treatment abroad. Czechia becomes attractive destination thanks neighbour position and low prices if compared with other member states.

9 Conclusions

Even authors of the Directive recognize that thin minority of patients will further seek treatment abroad.[42] Nevertheless, even marginal outflow of money to other member states can be sensitive. Considerable restrictions were thus accepted.

We can debate whether outflow of patients with public money for their treatment can also push into improvements of domestic healthcare. Approximation of classification of treatments and methods for calculations was also expected.[43]

Nevertheless, Scepticism about impact of the Directive is appropriate. The Court of Justice discovered right for reimbursement of healthcare intentionally sought and found abroad as emanation of free movement of services and goods not until 1998. Decades of building of common market were necessary until the first impulse for healthcare integration beyond coordination for migrants and urgent treatment. The member states showed considerable fears. Nevertheless, judicial impulse was strong enough to be downplayed. Legislative refinement was perceived as the best option by most of them including Czechia, with considerable exception of Poland and Slovakia. Finalization, however, requires another decade.

The model was developed cautiously to survive. European nations enjoy further different healthcare. Any significant solidarity among the member states is not expected, contrary to different approach towards mobility of students requiring hospitality towards incomers.

We shall thus ascertain cautiously whether any "European healthcare union" (Vollaard, Bovenkamp & Martinsen, 2016) emerges. It is far from significant federal contribution to healthcare which is fundament of federal legislative interventions in the United States of America. (Obinger, Leibried & Castles, 2005) New member states in central Europe form surely periphery of such union.

Notes

[1] In case of patient mobility and cross-border healthcare, among others (Glinos, Baeten & Maarse, 2010)

[2] See http://pliticalscience.ku.dk/research/healthcare_regulation_in_the_european_union/ (retrieved 2016-06-08)

[3] Judgment of the Court of Justice of 31.1.1984 G. Luisi and G. Carbone v. Ministero del Tesoro, reference for a preliminary ruling Tribunale civile e penale di Genova (Italy), 286/82 and 26/83, ECR 00377.

[4] Attempts to ban travel for abortion by Irish authorities in Attorney General v. X (1992) IESC 1, 1 IR 1 resulted into adoption of the Thirteen Amendment of the Constitution of Ireland guaranteeing freedom to travel abroad as rule deprioritizing protection of the unborn.

[5] 2003/752/EC: Decision No 190 of 18.6.2003 concerning the technical specifications of the European health insurance card, L 276, 27/10/2003 p. 0004-0018.

[6] Judgment of Court of Justice, 28. 4. 1998 R. Kohll v. Union des caisses de maladie, reference for a preliminary ruling of Cour de cassation (Luxembourg), C-158/96, I-01931.
[7] Judgment of the Court of Justice, 28. 4. 1998, N. Decker v. Caisse de maladie des employés privés, reference for a preliminary ruling of Conseil arbitral des assurances sociales (Luxembourg) C-120/95, I-01831.
[8] For detailled analysis of the case-law see (Soytürk, 2012).
[9] Interview with an official of the public health insurance fund involved (Prague, 13.10. 2013)
[10] Prior authorization can be required solely for reimbursement of treatments addressed by another Cabinet decree defining maximal waiting periods for some treatments.
[11] http://www.kancelarzp.cz, http://www.cmu.cz
[12] Interview with official of *Všeobecná zdravotná poisťovňa*, 17. 9. 2014.
[13] For detailled information of presentation. http://www.udzs-sk.sk
[14] Numerous cases can be found in database of judgments of the *Naczelny sad administracyjny* (the Superior Administrave Court) a regional administrative courts http://www.orzeczenia.nsa.gov.pl if judgments of the Court of Justice are inserted in full-search tool. The courts were largely reluctant to apply free movement of services as interpreted by the Court of Justice, but accepted argumentation for correction of refusal of prior authorization in cases of treatment unavalable in Poland.
[15] The first judgment concerned cataract surgery found in Czechia after waiting for such treatment in Poland for several years, see (Pachocki, 2014).
[16] *Ustawa o zmianie ustawy o swiadczeniach opieki zdrowotnej finansowanych ze srodkow publicznych*, Dz. Ust. 2014/1491.
[17] Limits and reserves fixed in Art. 11 of *ustawa* 2014/1491 (above) are fixed for years 2014-2023. Sums are considerable, surpassing 1.000.000.000 PLN per year, which is magnitude two of Czech expenditures.
[18] NFZ differentiates at institutional level urgent treatment, planned treatment according to the regulation and treatment reimbursed according the Directive and its implementation, the latter managed by *Krajowy punkt kontaktowy do spraw transgranicznej opieki zdrowotnej* (country contact point for cross-border healthcare), see http://www.kpk.nfz.gov.pl/pl/.
[19] Surprisingly, private insurers do not attempt to reduce expenditures with recovery of claim towards public health insurance funds for reimbursment of urgent treatment in
[20] See press Tisková zpráva 13.11.2015.
[21] See Internet presentation of Czech healthcare offering treatment for foreigners in English, German and Russia supported by grants of ministries of healthcare and regional development http://www.medicaltourism.cz.
[22] See (Vlková, 2016).
[23] Figures are from time to time presented jointly by public health insurance funds. Haemophiliacs with rare adverse effects are the most expensive. There is considerable disparity among funds.
[24] 56.394.373 CZK (approximately 2.000.000 EUR) was transferred as financing for 829 planned treatments of Slovaks to Czech hospitals (CMU Yearbook 2014) through channels expected by the coordination regulations.

[25] Interview with official of *Všeobecná zdravotná poisťovňa* (17. 9. 2014), that correctional operation of cornea improving vision were declared frequently as cataract surgery despite its limited incidence among young people. in eye clinic in nearby Zlín. Planned birth in Austria was declared as sudden. Similar phenomenon was reported in Slovenia (discussion at conference *Cross-border delivery of healthcare in the EU*. Rijeka, 2012).

[26] I was informed by Slovak student in Brno about specific orthopaedic surgery she underwent in specialized Czech hospital because her orthopaedist in Slovakia refused to provide due to lack of experience. Public health insurance fund promised to reimburse significant part of her expenditures according to an individual calculation.
[27] See http://www.llp.cz. Disinterest can be explained with limited political impact of any advocacy in the field.
[28] One regional hospital in vicinity of Poland discussed the feasibility of assistance to their potential Polish patients. Another private hospital in Brno oriented at superior healthcare advertises the assistance with administration in the member state of affiliation to the social security.
[29] It can be debated whether article 8 (2)(c) of the Directive would allow for restriction of reimbursment of home births if discouraged by Czech legislation restricting assistance of midwives.
[30] The most vivid is Svaz pacientů České republiky, see http://www.pacienti.cz, other organizations are largely defunct. The list of organizations of patients suffering from particular diseases and disabilities can be found at http://www.sukl.cz/sukl/pacientske-organizace.
[31] Their independence from the Ministry of Healthcare can be demonstrated with such lobbying aimed at deputies of both government and opposition parties.
[32] Among others, blogs "Prawa pacjenta" (Patient Rights) http://www.blogprawapacjenta.com.pl and "Gazeta Prawna" http://gazetaprawna.pl)
[33] For detailed political analysis see (Vasev & Vrangbaek, 2014)
[34] Judgment 67545/09 of 14. 10. 2010.
[35] Judgment 28859/11 and 28473/12 of 11. 12. 2014, but referred to the Grand Chamber.
[36] Judgment Pl. ÚS 19/13 of 22.10. 2013.
[37] Article 18 TFEU, Judgment of the Court of Justice of 3. 10. 2010, *A. Ferlini v. Centre hospitalier de Luxembourg* reference for preliminary ruling *Tribunal d'arrondissement de Luxembourg* , C-411/98, I-08081.
[38] Among the three countries, Czechia is the closest to Bismarck model praised repeatedly by authors of annual European Health Consumer Indexes under parole „Bismarck beats Beveridge" (see below EHCI 2015, p. 20).
[39] (Björnberg, 2016). However, penalization for restrictions on abortions (p. 93) affecting Poland deserves discussion due to its moral relevance.
[40] See initiative JuSani (http://jusani.de) of Saxonian healthcare providers. Web pages established in 2013 stagnate and promised tools for seeking of providers in both northern part of Bohemia and Saxony were not established. There is no information about expected cooperation of hospitals.
[41] See (Bocquet, Smit, Couffignal & Lair, 2009).
[42] Recital 39 of the Directive.
[43] See (Riedel, 2016).

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